PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2011-D4

PROVIDER –
Sonoma Valley Health Care District
Sonoma, CA

Provider No.: 05-0090

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING -
April 28, 2010

Cost Reporting Period Ended -
June 30, 2000

CASE NO.: 06-0828

INDEX

ISSUE:

Whether the Intermediary's reclassification of clinic meals statistics on Worksheet B-1 from the reimbursable "clinic" cost center (clinic) to a non-reimbursable cost center was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The objective of the Medicare cost reporting process is determining how much of a provider's allowable cost should be apportioned to the Medicare program. As part of that apportionment process, a facility's overhead costs such as building depreciation, administrative and general expenses, and dietary costs are allocated to the revenue-producing departments such as radiology, laboratory, and the therapy cost centers. This process is known as "cost finding." 42 C.F.R. §413.24(d). The Medicare reimbursement manuals and guidelines set forth the allocation bases (square footage, accumulated cost, meals served, etc.) upon which, as well as the order in which, the non-revenue producing cost centers are allocated to the revenue-producing cost centers.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sonoma Valley Health Care District (Provider) provides general acute care and skilled nursing facility services in Sonoma, California. When the Provider prepared its Medicare cost report for the fiscal year ended June 30, 2000, it allocated the costs of the overhead department "Dietary" to other departments based upon the statistic "meals served." The outpatient department Clinic

received a portion of the Dietary cost center costs based upon the 264 meals served in that clinic.[1] National Government Services, LLC (Intermediary) reviewed the Provider's cost report and concluded that allocation of dietary costs to an outpatient cost center was improper. The Intermediary adjusted the Provider's cost report by removing the statistic from the outpatient cost center and adding it to the non-reimbursable cost center titled "Nonpatient Meals." [2]

The Provider appealed several of the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-1841 and met the jurisdictional requirements of those regulations. Only one issue remains in the case with the amount of Medicare funds in controversy of approximately $1,278.[3] The Provider was represented by Glenn S. Bunting, of Toyon Associates, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends the clinic meals at issue were served to patients in the Clinic and are an allowable cost. In order to achieve proper Medicare cost finding, the Clinic meal cost must be reflected in the Clinic cost center. The Medicare cost report allocates the cost of meals in the Dietary department based upon "meals served" statistics. The Intermediary's reclassification of the 264 clinic meals served in the clinic from the Clinic cost center to the non-reimbursable cost center non-patient meals eliminated dietary costs from the Clinic. The Provider believes this violates the cost shifting principle found at 42 C.F.R. §413.53(a) which states in part:

> Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. . . .

The Provider notes that Provider Reimbursement Manual (PRM 15-1) §2105.2 cited by the Intermediary in its audit adjustment[4] does not apply to the circumstances at issue.

The Intermediary asserts meals served to outpatients are not covered expenses under PRM 15-1 §2202.14, which states:

> Outpatient services include services that are diagnostic in nature as well as those services and supplies which are incident to the services of physicians in the treatment of patients.[5]

The Intermediary interprets this section to exclude the cost of meals from reimbursable costs for

[1] See Provider exhibit P4 for meals statistics.
[2] See Provider exhibit P3, adjustment number 42.
[3] See Provider Final Position Paper pg 4.
[4] See Provider Final Position Paper pg 3.
[5] See Intermediary exhibit I-4, pages 6-7.

outpatient beneficiaries. Therefore, it believes it properly allocated these costs to the non-reimbursable cost center.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes the Provider failed to show that dietary costs allocated to the outpatient Clinic are related to patient care under 42 C.F.R. §413.9, which requires:

> [a]ll payments to providers for services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services. . . .

This regulation goes on to define "necessary and proper costs:"

> (2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

42 C.F.R. §413.9(b)(2)

The Board finds that patient meals costs at issue are not "common and accepted occurrences" in an outpatient setting. In fact, the outpatient meals are not even a "common and accepted occurrence" at the Provider's facility. There were 264 meals[6] served in the Clinic. The Board notes that the small number of meals (less than one per day) and the lack of outpatient meals in any other outpatient department indicate that dietary costs are not a "common and accepted occurrence" in this hospital. Although being a common and accepted occurrence is not in itself a requirement to be an allowable cost, the Board finds that in cases such as this, further documentation is needed to determine if these outpatient meals are related to patient care.

An example of how the Provider could have supplied evidence to prove its costs were necessary and proper is found in the CMS Administrator's decision in St. Mary's Hospital vs. The Travelers Insurance Company, PRRB Decision No. 84-D3, October 25, 1983. In St. Mary's Hospital the outpatient meals were allowed as part of covered dialysis services based upon expert testimony showing "an apparent relationship between the meals served to these patients and their health during and immediately after dialysis." Id. at page 4. The Board finds no evidence in the record as to why outpatient meals were necessary and proper for the Clinic patients' health in this case.

[6] See Provider Exhibit P-4.

Since the outpatient meals are not documented to be necessary and proper the regulations say they are not an allowable cost:

> Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operation costs include amounts not related to patient care . . . (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. . . .

42 C.F.R. §413.9(c)(3).

Finally, the Board did not find either party's argument persuasive. The Board notes the Provider's argument focuses on the apportionment of total allowable costs under 42 C.F.R. §413.53(a). The Board finds this regulation addresses how to apportion **allowable costs** between the beneficiaries of the Medicare program and other patients. Since the outpatient meal costs have been determined not to be allowable costs, they should not be allocated to the reimbursable outpatient Clinic, from which some of the costs would be apportioned to Medicare. The Board finds the outpatient meal costs determined to be not allowable were appropriately allocated to a non-reimbursable cost center.

The Intermediary on the other hand focuses on outpatient covered services rather than allowable costs. The Board agrees with the CMS Administrator's Decision in St. Mary's Hospital showing that outpatient meals themselves are not a covered service but can be a part of covered outpatient services. As stated in St. Mary's Hospital, meals were "part of a general group of services rendered in the course of renal dialysis [an outpatient service]." Id. at page 4. Had the Provider shown that the outpatient meals were necessary for the patients' health while receiving treatment at the Clinic, the outpatient meal costs may have been allowable. The Intermediary's theory that outpatient meals are not a specific covered service and therefore their cost is never allowable is not correct.

The Provider failed to document that the outpatient meals provided to Clinic patients were a necessary part of their covered clinic service. Therefore, the Board finds the Intermediary's reclassification of these meals to a non-reimbursable cost center appropriate.

DECISION AND ORDER:

The Board finds that the Intermediary's determination to include Clinic outpatient meal statistics in a non-reimbursable cost center was proper. The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: October 22, 2010